Ohio Department of Job and Family Services

CREDENTIALS OF PROFESSIONAL PROVIDERS OF PASSS FUNDED THERAPEUTIC SERVICES AND MEMORANDUM OF UNDERSTANDING

Child's Name *(first and last)*	Date of Birth
Specify the therapy being provided to the child	
Professional Experience (please describe your professional experience with the therapy you will provide to the child)	
Education and Training (please list all specific education and training relative to the therapy you will provide to the child)	
Professional Credentials	
Name of Provider *(first and last)*	
Name of Practice/Office	
Street Address of Practice/Office	
City, State and Zip Code	(Area Code) Telephone Number
Ohio License #	Licensing Board
My therapeutic interventions will comply with all treatment aspects contained in Ohio Administrative Code rules 5122-26-16 "Seclusion, restraint and time-out," 5122-26-16.1 "Mechanical restraint and seclusion," and 5122-26-16.2 "Physical restraint" I proclaim competence to the therapeutic technique(s) specified and acknowledge that my practice is governed under laws and rules of the occupational regulatory board specified above.	
Signature of Provider of Service(s)	Date